93-684

No.

Supreme Court, U.S.
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IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

ATLANTIC HEALTHCARE BENEFITS TRUST,
NATIONAL INSURANCE CONSULTANTS, INC.,
UNITED HEALTH ASSOCIATION OF AMERICA, *et al.*,
Petitioners,

v.

CONSTANCE B. FOSTER, INSURANCE COMMISSIONER
OF THE COMMONWEALTH OF PENNSYLVANIA, *et al.*,
Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

---

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. WHETHER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) PREEMPTS THE STATE OF PENNSYLVANIA FROM OUTLAWING SELF-FUNDED MULTIPLE-EMPLOYER ERISA WELFARE BENEFIT PLANS UNDER THE GUISE OF PERMISSIBLE STATE REGULATION BY DECLARING SUCH PLANS TO BE ILLEGAL INSURANCE COMPANIES THAT MUST RESTRUCTURE AS STATE-LICENSED INSURANCE COMPANIES OUTSIDE THE SCOPE OF ERISA IN ORDER TO PROVIDE EMPLOYEE BENEFITS TO PENNSYLVANIA RESIDENTS;

2. WHETHER THE STATE OF PENNSYLVANIA'S FAILURE TO ENACT LEGISLATION SPECIFICALLY DESIGNED TO REGULATE SELF-FUNDED MULTIPLE-EMPLOYER ERISA PLANS AND PROSECUTION OF SUCH PLANS UNDER EXISTING STATUTES DESIGNED TO REGULATE INSURANCE COMPANIES VIOLATES THE DUE PROCESS AND EQUAL PROTECTION CLAUSES OF THE U.S. CONSTITUTION.

PARTIES TO THE PROCEEDING

Petitioners ATLANTIC HEALTHCARE BENEFITS TRUST, UNITED HEALTH CARE ASSOCIATION OF AMERICA, AND NATIONAL INSURANCE CONSULTANTS, INC. were plaintiffs-appellants in Civil Action No. 93-7052, below.

Respondents CONSTANCE B. FOSTER, INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA AND THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA were defendants-appellees below.

The parties before this Court are the same as the parties below.

United Healthcare Association of America and National Insurance Consultants, Inc. have no parent or subsidiary corporations.

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Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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PETITION FOR A WRIT OF CERTIORARI

Atlantic Healthcare Benefits Trust, *et al.*, (Atlantic) respectfully petition for a writ of certiorari to review the judgment order of the United States Court of Appeals for the Third Circuit, entered in this proceeding on August 23, 1993.

OPINIONS BELOW

The Third Circuit Court of Appeals' Judgment Order without opinion is reprinted in the appendix (App.) at p. 1a. The district court decision, *Atlantic Healthcare Benefits Trust v. Foster*, is reported at 809 F.Supp. 365 (M.D. Pa. 1992) and reprinted in the appendix at p. 3a.

The unreported Order of the Insurance Commissioner of the Commonwealth of Pennsylvania, entitled *In Re:*

Atlantic Healthcare Benefits Trust, United Healthcare Association of America, National Insurance Consultants, Inc., Edward M. Zinner, and William E. Moulton, Docket No. P92-05-45, Before the Insurance Commissioner of the Commonwealth of Pennsylvania (Nov. 27, 1991), is reprinted in the appendix at p. 22a.

STATEMENT OF JURISDICTION OF THE COURT

The judgment of the Court of Appeals for the Third Circuit was entered on August 23, 1993, and no Petition for Rehearing was filed. This Court has jurisdiction to review the judgment of the Third Circuit pursuant to 28 U.S.C. § 1254(1).

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

29 U.S.C. § 1144. Other Laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * * *

(2)(A) Except as provided in subparagraph (B), nothing in this chapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under

such a plan, shall be deemed to be an insurance company or other insurer, bank, trust, company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * *

(6)(A) Nothwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

* * * *

Constitution of the United States of America, Amendment 14

Section 1. Citizens of the United States

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, we

citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

STATEMENT OF THE CASE

This case [1] concerns a critical health care access issue. Specifically, at issue is the ability of small business employers to band together and pool resources in order to self-fund a program of health benefits for their collective employees. The framework for self-funded employee benefit plans is set forth in the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. § 1001 *et seq.* Without the self-funding alternative to traditional health insurance (which in many cases is either prohibitively expensive or simply unavailable to certain businesses), the number of Americans without health insurance would far outnumber the current estimate totaling 37 million people.

ERISA provides for three primary forms of self-funded employee benefit plans: single-employer plans (usually formed by large corporations and companies under common control), "multiemployer" plans formed pursuant to collective bargaining efforts of organized labor unions, and "multiple employer welfare arrangements" (MEWAs), generally involving smaller businesses joined through an association of employers. With respect to self-funded single-employer and union plans, ERISA unequivocally provides an exclusive regulatory scheme and contains an

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[1] A companion petition for certiorari to the Second Circuit filed concurrently (*Atlantic Healthcare v. Googins*) discusses the identical issues in the context of the Connecticut insurance licensing statute. Consequently, certain elements of the Statement of the Case and Reasons for Granting the Writ appear in both petitions.

expansive preemption provision that prohibits states from regulating such entities under state insurance laws. Self-funded MEWAs that qualify as plans under ERISA are also within the federal regulatory scheme but are subject to a limited exception to preemption which allows the application of state insurance regulations which are not inconsistent with Title I of ERISA.

Ambiguities regarding the preemption exception pertaining to MEWAs have resulted in states adopting differing approaches to regulating such plans, making it difficult and in some cases impossible for such plans to provide benefits to residents of several states, as envisioned by Congress in enacting ERISA. Many states have enacted legislation specifically designed toward regulating self-funded MEWA ERISA plans. Other states have elected to allow such plans to provide benefits without state regulation. Several states, however, have exceeded their regulatory authority under the preemption exception by issuing bulletins or press releases declaring that self funded MEWA ERISA plans are "illegal insurers" that must cease operation as ERISA trusts and obtain a certificate of authority to transact the business of insurance, requiring restructuring and capitalization as a corporate insurance entity outside the federal regulatory scheme and completely a creature of state regulation, and allowed to provide benefits only upon the discretionary approval and issuance of an insurance license by the State. The State of Pennsylvania has followed the latter approach, making a public effort to prohibit its residents from obtaining employee benefits through such plans.

1. Department of Insurance action against Atlantic.

Atlantic Healthcare Benefits Trust is a self-funded trust organized in February 1991 pursuant to ERISA by United Healthcare Association of America (UHAA) and administered by National Insurance Consultants, Inc. (NIC). Atlantic was established by UHAA and is maintained and controlled by a benefit committee representative of the employers who participate in the trust, which provides a

pool of employer contributions from which to pay health and welfare benefits on behalf of the employer members of UHAA, the employees of such members and the dependents of such employees. Accordingly, Atlantic qualifies as an employee welfare benefit plan under ERISA, 29 U.S.C. § 1002(1), organized as a self-funded MEWA, 29 U.S.C. § 1002(40).

The Pennsylvania Department of Insurance (DOI) has adopted a policy that all self-funded MEWAs, including both those that qualify as employee welfare benefit plans under ERISA and those that do not, are unauthorized insurers under the insurance provisions of the Pennsylvania Statutes. The DOI determined that Atlantic was not an ERISA plan but was operating an insurance company without a license and ordered it to cease and desist providing benefits. In response, Atlantic brought an action for declaratory and injunctive relief against the DOI Commissioner in U.S. District Court seeking a determination that the trust qualified as a plan under ERISA and that State regulatory efforts requiring it to restructure as an insurance company and operate outside the scope of ERISA were preempted. Jurisdiction in the action was predicated on the exclusive federal jurisdiction provisions conferred on cases brought by plans and plan fiduciaries to determine rights under ERISA, 29 U.S.C. § 1132(e)(1).

2. The District Court Action.

Following the filing by Atlantic of an amended complaint in district court, the DOI brought a motion to dismiss the action under Rule 12(b)(6), F.R.Civ.P. The DOI asserted that as a matter of law, regardless of whether Atlantic qualified as an employee benefit plan under ERISA, as a self-funded MEWA it was subject to state insurance regulation requiring licensing as an insurance company and prosecution under unauthorized insurer statutes for providing employee benefits without a certificate of authority.

In opposition, Atlantic raised several key points. First, since the amended complaint alleged that Atlantic qualified as an ERISA employee welfare benefit plan, ERISA status must be assumed and not subject to challenge for the purposes of a Rule 12 motion to dismiss. Second, since Atlantic is assumed to be an ERISA plan, by definition it is not an "illegal insurance company" as asserted by the DOI. Finally, Atlantic asserted that the requirement of a certificate of authority to transact the business of insurance would remove any plan from the regulatory ambit of ERISA and bring it wholly within the State regulatory scheme, a result that would be inconsistent with and hence preempted by ERISA pursuant to 29 U.S.C. § 1144(b)(6)(A)(ii).

The district court ruled that it was unable to determine whether Atlantic qualified as a plan under ERISA but dismissed Atlantic's complaint on the ground that "even if Plaintiffs provide a covered employee benefit plan, it is a MEWA which may [under 29 U.S.C. § 1144(b)(6)(A)(ii)] be regulated by state laws not inconsistent with ERISA; a state licensing scheme is not inconsistent with ERISA." App. p. 21a.

3. The Third Circuit Court of Appeals' decision.

Atlantic argued vehemently before the Third Circuit Court of Appeals that the Pennsylvania insurance licensing scheme is inconsistent with and preempted by ERISA. The primary, dispositive reason supporting this conclusion is that Congress expressly intended to allow self-funded ERISA-plan MEWAs, which are required under ERISA to hold all assets in trust, to operate under the full scope of federal regulation provided by ERISA. The Pennsylvania statutes contain no provisions for licensing trusts as insurance companies; only incorporated entities (not permissible for self-funded ERISA plans) may obtain a certificate of authority to operate an insurance company.

Moreover, ERISA expressly allows multiple employers to form qualifying employee benefits plans to provide benefits to their employees. Issuance of a certificate of authority by the State of Pennsylvania is discretionary. Allowing the imposition of a certificate of authority requirement against plans of the State's choosing under existing State law without a uniform scheme to cover all self-funded MEWAs thus raises constitutional concerns by denying small business employers equal access to the benefits provided under ERISA and providing a mechanism for the State to arbitrarily pick and choose those plans which it will eliminate by requiring an insurance license.

Notwithstanding the foregoing, the Third Circuit affirmed the district court decision. The Court of Appeals issued a one-sentence Judgment Order, citing *Atlantic Healthcare v. Googins*, No. 92-7955, 1542 AUG TERM 1992, 1993 WL 28672, 1993 U.S. App. Lexis 19774 (2d Cir. Aug. 3, 1993) (an inapposite case involving the Connecticut insurance statutes)[2] and the district court decision. This Petition follows.

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[2] Atlantic's petition for a writ of certiorari in the *Atlantic Healthcare v. Googins* action is premised on the grounds that the Second Circuit incorrectly interpreted 29 U.S.C. § 1144(b)(6)(A)(ii) to authorize regulation of self-funded ERISA plan MEWAs as insurance companies under Connecticut law and failed to acknowledge the unconstitutional implications of its ruling.

REASONS FOR GRANTING THE WRIT

I. THE COURT OF APPEALS' DECISION RAISES IMPORTANT ISSUES CONCERNING THE ABILITY OF SMALL BUSINESS EMPLOYERS TO POOL RESOURCES IN ORDER TO SELF-FUND A BENEFIT PROGRAM UNDER ERISA AND CONFLICTS WITH DECISIONS BY THIS COURT AND OTHER COURTS OF APPEAL.

This case raises an important issue regarding health benefits, a topic that is on the forefront of discussion across the entire nation. With historic efforts currently under way to work toward a solution to the country's health care crisis, the action of the State of Pennsylvania to increase the number of uninsured Americans through a crusade to eliminate self-funded multiple employer benefit plans borders on the unconscionable. The decision of the Third Circuit condones the use of ERISA by the States to take away the right to self fund health benefit programs that Congress has expressly given and which Congress determined not to withdraw when it amended ERISA to provide for limited State regulation concurrent with the full scope of federal regulation. Since such State action is inconsistent with Congressional intent and preempted by ERISA, this Court should grant *certiorari* to resolve interpretative ambiguities, approaches and conflicts among the states and enunciate a clear explication of ERISA preemption as applicable to self-funded MEWAs.

This Court has examined the scope of permissible state regulation with respect to self-funded ERISA plans and firmly ruled that all regulation under State insurance laws is preempted. *FMC Corp. v. Holliday*, 111 S.Ct. 403 (1990). The State of Pennsylvania Department of Insurance and the Third Circuit have apparently chosen to limit this Court's ruling in *FMC* so as to be inapplicable to self-funded MEWAs. Yet the identical justification set forth in *FMC* (referring to several articles outlining

the inability of pre-ERISA state insurance statutes to effectively regulate uninsured or self-funded benefit programs) exists supporting preemption of state insurance licensing laws imposed upon multiple employer plans.

The fact is that a licensing requirement is a ruse under the guise of permissible state regulation utilized by states such as Pennsylvania to abolish self-funded plans. Such states view these plans as competitive enemies to traditional insurance concerns that pay generously into the state coffers through premium taxes and mandatory contributions to claims guarantee funds. ERISA plans are immune from such obligations under strict fiduciary principles that require all plan assets to inure solely to plan participants for the payment of benefit claims and reasonable administrative expenses. 29 U.S.C. § 1103 (c)(1). Transforming an ERISA plan into an insurance company would result in subjection of the plan to these state economic burdens and compel the subsidization of programs outside the ERISA plan contrary to fiduciary obligations.

Congress enacted ERISA to provide a federal regulatory framework for employee pension and health plans and specifically created a mechanism for self-funding benefit plans by providing in 29 U.S.C. § 1002(1) that benefits may be funded "through the purchase of insurance or otherwise." Plans offering benefits to the employees of two or more employers may self-fund a pooled benefit program under the definition of MEWA in Section 1002(40), subject to limited state regulation under 29 U.S.C. § 1144(b)(6)(A)(ii), the exception to ERISA's broad preemption clause at issue in this case.

The language of ERISA's preemption clause reads, in pertinent part, as follows: "Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

The "savings clause" in the subsequent subsection provides limits to preemption: "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." Section 1144(b)(2)(A). Thus, insurance companies are not afforded protection against state laws regulating insurance by virtue of the savings clause.

The "deemer clause," immediately following the savings clause, makes emphatically clear that *no benefit plan described in Section 1003 may be deemed to be an insurance company or other insurer* "for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts." Section 1144(b)(2)(B) (emphasis supplied).

In 1982, in reaction to complaints about a small number of fraudulent schemes resembling ERISA plans, the Erlenborn-Burton Act was passed, creating 29 U.S.C. Section 1144(b)(6)(A). This provides a limited exception to the preemption rules for MEWAs. A distinction is made between fully insured MEWAs and self-insured or partially insured (through the purchase of stop loss or reinsurance coverage) MEWAs. In regard to self-funded (and partially insured) MEWAs, such as Atlantic, the amendment provides that, *in addition to ERISA,* "any law of any state which regulates insurance may apply *to the extent not inconsistent with the preceding sections of this subchapter.*" 29 U.S.C. Section 1144(b)(6)(a)(ii) (emphasis added).

Congress thus intended the federal regulatory scheme of ERISA under the jurisdiction of the U.S. Department of Labor to continue to govern benefit plans, potentially supplemented by additional, limited application of some state insurance regulations. This conclusion is confirmed in the legislative history of the amendment, particularly the Congressional record: "With respect to multiple employer welfare arrangements which do meet the definition of welfare plan, the amendment amends the ERISA pre-

emption provision to permit limited State regulation of such plans while retaining the full scope of the Federal regulation which is presently applicable." 128 *Cong.Rec. House* 30367 (Dec. 13, 1982).

In *FMC v. Holliday, supra,* and *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), this Court observed that ERISA treats insured plans and self-funded plans differently for preemption purposes. The reason for the difference is grounded in the interaction of the savings and deemer clause with the general preemption clause. In essence, state insurance regulation of insured plans is permissible, *but state insurance regulation of self-funded plans is preempted. Holliday,* 111 S.Ct. at 407-11; *Metropolitan Life,* 471 U.S. at 738-47. This Court reasoned that the distinction between insured and self-funded plans follows directly from the statute. "State laws that directly regulate insurance . . . do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies." *Holliday,* 111 S.Ct. at 409. It is not possible for an ERISA plan to comply with Pennsylvania statutes requiring licensing as an insurance company. Specifically, a trust may not be licensed as an insurance company under the Pennsylvania certificate of authority provisions, 40 P.S. § 46, and ERISA 29 U.S.C. § 1103(a) requires that all plan assets, other than insurance contracts and assets held by an insurance company contracting with an ERISA plan, be held in trust. A plan thus cannot operate under ERISA and concurrently function as a Pennsylvania licensed insurance company. Since ERISA mandates that plans remain subject to the full scope of federal regulation in addition to insurance law that is not inconsistent with ERISA, an insurance licensing requirement preventing a plan from complying with the important fiduciary provision set forth in 29 U.S.C. § 1103(a) is preempted.

ERISA's fiduciary provisions also require that trust funds be held for the exclusive purpose of providing bene-

fits to participants and beneficiaries and defraying reasonable administrative expenses. 29 U.S.C. § 1104(a)(1)(A). Funding capital, surplus and reserves in excess of $1,125,000.00 as required under the Pennsylvania licensing statutes, 40 P.S. §§ 386, 421, and requiring the payment of premium taxes and contributions to state claims guarantee funds for insolvent insurance companies would violate ERISA fiduciary law. Such requirements are thus inconsistent with ERISA and preempted.

Further, the restructuring of ERISA plans into insurance companies would subject the plans to the entire State law remedial scheme (unfair insurance practices acts, bad faith actions, and causes of action for fraud and punitive damages, among others) from which the framers of ERISA unequivocally intended to shield ERISA plans in order to preserve their economic ability to viably self-fund a benefit program without the specter of large court judgments threatening financial stability. This Court has consistently ruled that such state law remedies are preempted and unavailable to plan participants, which may bring actions against ERISA plans solely for the recovery of benefits under federal law. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1989).

In a recent decision involving an identical challenge by Atlantic to a licensing requirement under Connecticut law, *Atlantic Healthcare Benefits Trust v. Googins, supra*, held that the Connecticut scheme was not preempted by ERISA. The Second Circuit showed respect for Congressional intent that self-funded MEWA ERISA plans operate under both federal and state law by premising its ruling on the finding [3] that a trust could be licensed

[3] The Second Circuit also ruled without supporting explanation that the associated economic consequences of state regulation were not inconsistent with federal regulation and ignored this Court's express proscription against subjecting ERISA plans to state law remedial schemes. The Second Circuit also displayed a misunderstanding of the structure of self-funded programs by citing capital

as an insurance company in Connecticut. This would not be possible in Pennsylvania, yet the Third Circuit cited the Second Circuit's conflicting decision as controlling authority in its single-sentence Judgment Order.

The Third Circuit interprets this Court's decision in *FMC* to find for preemption if a statute has either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state. *United Wire Welfare Fund v. Morristown Mem. Hospital,* 995 F.2d 1179, 16 EBC 2182, 2187-2189 (3d Cir. 1993). A certificate of authority requirement constitutes a direct interference that imposes requirements on the internal design and structure of plans. Subjecting multi-state plans to differing certificate of authority requirements of differing states would make operation impossible. Consequently, the Third Circuit should have followed its own authority in *United Wire* and found Pennsylvania licensing statutes as applied to Atlantic preempted by ERISA.

Because the Pennsylvania Certificate of Authority statutes conflict with ERISA and make compliance thereunder and concomitant operation as an ERISA plan a "physical impossibility," the licensing requirement upheld by the Third Circuit should have been ruled preempted. *Florida Lime & Avacad. Growers v. Paul,* 373 U.S. 132, 142-43 (1963) (state statute preempted if physically impossible for compliance with both state and federal statute).

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and reserves requirements for fully-funded MEWAs under 29 U.S.C. § 1144(b)(6)(A)(i) as a basis for the conclusion that the MEWA amendment contemplates similar requiremnts for self-funded MEWAs. The economic standards for reserves and contribution levels in actuality regulate the carrier insuring the MEWA, not the plan itself. Consequently, such entities must be funded in conformity with state requirements for insurance companies. No such requirements are necessary or applicable to self-funded plans.

II. THE COURT OF APPEALS' DECISION RAISES AN IMPORTANT CONSTITUTIONAL ISSUE CONCERNING THE ABILITY OF STATES TO USE A LIMITED EXCEPTION TO ERISA PREEMPTION OF STATE INSURANCE REGULATION TO PROHIBIT MULTIPLE EMPLOYER ERISA PLANS FROM OPERATING UNDER ERISA TO PROVIDE BENEFITS TO RESIDENTS OF A STATE BY REQUIRING SUCH PLANS TO RESTRUCTURE AS INSURANCE COMPANIES IN ORDER TO BE REGULATED EXCLUSIVELY BY THE STATE AND ONLY IF THE STATE ELECTS TO ISSUE AN INSURANCE LICENSE AND CONFLICTS WITH DECISIONS BY THIS COURT.

The MEWA amendment allows states to enact regulations consistent with ERISA to apply to self-funded MEWA ERISA plans. Existing insurance statutes of general applicability to insurance companies are neither designed nor equipped to regulate ERISA plans. *In Re Affiliated Food Stores, Inc. Group Ben. Tr.,* 134 B.R. 215 (N.D. Tex. 1991); *FMC Corp. v. Holliday,* 111 S.Ct. at pp. 412-414 (Stevens, J. dissenting).

Several states have responsibly promulgated regulations specific to self-funded MEWAs.[4] By contrast, Pennsylvania has no regulatory scheme for the licensing or supervision of self-funded MEWAs. Such plans, *even if they qualify as ERISA plans,* are deemed to be fraudulent, unlicensed insurance companies and prosecuted as such. Pennsylvania's conduct thus falls squarely within ERISA's preemption clause and implicates violations of constitutional rights.

The State of Pennsylvania provides no notice to self-funded plans that they are (in the view of the DOI) "illegally" providing benefits to Pennsylvania residents;

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[4] *See, e.g.,* Fla. Stat. Section 624.437 (1991); Mich. C.L. Section 500.7050 (1991); N.M. Stat. Ann. Section 59A-15-20; N.C. Gen. Stat. Section 58-49-1, *et seq.*; 1992 Okla. ALS 374 (S.B. 400).

the DOI simply executes seek and destroy tactics which it admits are designed to close down, rather than regulate, any self-funded MEWA coming to the attention of the DOI. In other words, the right to self-fund a benefit program for employees is taken away by the State of Pennsylvania in excess of jurisdiction and without due process of law under the Fourteenth Amendment of the U.S. Constitution.

Moreover, without a uniform set of regulations applicable to all self-funded MEWAs, equal protection concerns are triggered. The Commissioner is in a position to make arbitrary and perhaps discriminatory decisions by invoking unauthorized insurer statutes to prevent MEWAs of her choosing from providing employee benefits while allowing others to continue. The potential for abuse under such a selective enforcement scheme is obvious: powerful, well-funded special-interest groups such as the Blue Cross/Blue Shield entities might persuade regulators to target MEWAs that threaten their market share, and the State interest in premium taxes might further motivate the Commissioner to accommodate such a pursuit under the mantle of "protector" of consumers' interests.

Finally, access to self-funded benefit plan arrangements is expressly provided to employers under the authority of ERISA. Since issuance of a certificate of authority is within the sole discretion of the State of Pennsylvania, the State is improperly empowered to block employer access to the federal regulatory program by denying a license request.

Had Congress intended in amending ERISA to allow states to abolish self-funded benefit plans, it would have so provided. The regulatory and interpretative confusion following the amendment of ERISA and contributing to the abrogation of self-funding rights and violations of due process and equal protection under the laws is a result repugnant to ERISA and the Constitution of the

United States that affects the benefits of thousands utilizing MEWAs nationwide. This Court can rectify the problem by granting *certiorari*.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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November 1, 1993

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 93-7052

ATLANTIC HEALTH CARE BENEFITS TRUST; UNITED HEALTHCARE ASSOCIATION OF AMERICA; NATIONAL INSURANCE CONSULTANTS, INC.; EDWARD M. ZINNER; WILLIAM E. MOULTON; CHARLES R. ZIMMERMAN and HAROLD W. KING

v.

CONSTANCE B. FOSTER, Insurance Commissioner of the Commonwealth of Pennsylvania; INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA; CHRIS MONAHAN, Individually and as an Official of the Pennsylvania Insurance Department; CYNTHIA M. MALESKI, Individually and as Insurance Commissioner of the Commonwealth of Pennsylvania

ATLANTIC HEALTH CARE BENEFITS TRUST,
Appellant

On Appeal from the United States District Court
for the Middle District of Pennsylvania
(D.C. Civil No. 92-00551)
District Judge: Hon. Sylvia H. Rambo

Argued August 12, 1993

Before: SCIRICA, COWEN and SEITZ,
Circuit Judges

JUDGMENT ORDER

After considering the contentions raised by appellant, it is

ADJUDGED AND ORDERED that the judgment of the district court entered December 28, 1992, be and is hereby affirmed. *See, Atlantic Health Care Benefits Trust v. Foster,* 809 F.Supp. 365 (M.D. Pa. 1992); *Atlantic Healthcare Benefits Trust v. Googins,* No. 92-7955, 1542 AUG TERM 1992, 1993 WL 286792 (2nd Cir. Aug. 3, 1993). Costs taxed against appellant.

By the Court,

/s/ Robert E. Cowen
Circuit Judge

ATTEST:

/s/ P. Douglas Sisk
P. DOUGLAS SISK
Clerk

Dated: Aug. 23, 1993

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

Civil Action No. 3: CV-92-0551

(Consolidated Actions)

ATLANTIC HEALTH CARE BENEFITS TRUST, UNITED HEALTH CARE ASSOCIATION OF AMERICA, NATIONAL INSURANCE CONSULTANTS, INC., EDWARD M. ZINNER, and WILLIAM MOULTON,

Plaintiffs

v.

CONSTANCE B. FOSTER, INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA; and the INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA,

Defendants

CHARLES R. ZIMMERMAN,

Plaintiff

v.

CONSTANCE B. FOSTER, INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA; and the INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA,

Defendants

HAROLD W. KING,

Plaintiff

v.

CONSTANCE B. FOSTER, INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA; and the INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA,

Defendants

MEMORANDUM

[Filed December 23, 1992]

Before the court is Defendants' motion to dismiss Plaintiffs' complaint pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). Plaintiffs seek a declaration that Pennsylvania insurance laws regulating its benefits plan are preempted by ERISA, and further seek to enjoin the Commissioner from interfering with their benefits plan. Defendants assert that they are immune from suit pursuant to the Eleventh Amendment, and that Plaintiffs' complaint fails to state a claim since state licensing regulations are not preempted by ERISA as Plaintiffs allege. The matter has been fully briefed and is now ripe for consideration.

Background

The following facts are undisputed by the parties; any contested points will be noted by the court: On February 1, 1991, Edward Zinner and William Moulton created Atlantic Health Care Benefits Trust ("Atlantic"). Plaintiff United Health Care Association of America is a group of employers who provide their employees coverage through Atlantic. Plaintiff National Insurance Consultants administers Atlantic. Plaintiffs Zimmerman and King are insurance agents working with Atlantic. On June 28, 1991, the Pennsylvania Insurance Department claimed that Plaintiffs were operating an insurance company without the proper license required by 40 Pa. Cons. Stat. Ann. § 46. Subsequently, on November 27, 1991, the Commissioner ordered Atlantic to cease and desist solicitation of subscribers, renewal of policies, or acceptance of premium payments.

Defendants in the captioned case are Cynthia M. Maleski, the Commissioner for the Pennsylvania Insurance Department, who has been sued both in her individual

and official capacities, and the Insurance Department itself.[1]

Plaintiffs seek declaratory relief, to obtain clarification of the interplay between federal and state law, and injunctive relief, to prevent Defendants' allegedly unlawful interference in the benefits plan. Plaintiffs contend that Pennsylvania's regulation of Atlantic is preempted, and thus precluded by the Employee Retirement Security Act of 1974 ("ERISA"), which purportedly governs Plaintiffs' scheme.

Discussion

I. Eleventh Amendment

A. Introduction

Defendants assert that this court has on subject matter jurisdiction over the captioned action because of Eleventh Amendment immunity afforded states and their agencies. As the present suit implicates a state body and a state official, Defendants seek dismissal of the captioned case pursuant to Federal Rule of Civil Procedure 12(b)(1).

The Eleventh Amendment provides:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity commenced or prosecuted against any one of the United States by citizens of another State, or by citizens or subjects of any Foreign State.

This amendment, while facially applicable to both states and state officials, has been differently interpreted in the two instances.

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[1] Ms. Maleski has replaced Ms. Foster who was originally named as Insurance Commissioner in the captioned suit.

B. Suit against Pennsylvania Insurance Department

The Eleventh Amendment has always been interpreted as precluding suit against a *state* without a waiver of immunity by the state. Furthermore, the *Ex Parte Young* doctrine, discussed below, does not alter the fundamental prohibition against directly suing a state. *Ex Parte Young*, 209 U.S. 123 (1908). *See also Alamaba v. Pugh*, 438 U.S. 781, 782 (1978).

Nor may a *state* body be sued without a waiver of immunity. This bar to suit just as clearly applies to Commonwealth agencies as it does to the Commonwealth itself. *See Helfrich v. Pennsylvania, Department of Military Affairs*, 660 F.2d 88, 90 (3d Cir. 1981) (Department of Military Affairs immune from suit due to Eleventh Amendment); *Pugh*, 438 U.S. at 782 (Board of Corrections immune due to Eleventh Amendment). Plaintiffs concede that the Pennsylvania Insurance Department is an arm of the Commonwealth. Complaint at ¶ 8. Moreover, there is no indication that the Commonwealth *has* consented to this suit. Thus, Defendants are correct that Plaintiffs' suit must fail as to defendant Insurance Department of Pennsylvania. The Insurance Department will be dismissed from the case.

C. Suit against Pennsylvania Insurance Commissioner

The words of the Eleventh Amendment would appear to preclude federal courts from granting injunctive relief to ensure that states, through state officials, conform to constitutional or federal law. However, case law has not so interpreted the Eleventh Amendment.

The seminal case, *Ex Parte Young*, held that any state official acting inconsistently with the federal Constitution is "stripped of his official or representative character and is subjected in his person to the consequences of his individual conduct." *Ex Parte Young*, 209 U.S. at 160.

Thus, *Ex Parte Young* created a fiction to enable state officials to be required to comply with federal law—if a state official's actions are not in compliance with federal law, the acts are deemed not to be sanctioned by the state, thereby permitting a personal suit against the officials to go forward. Because of the fiction of *Ex Parte Young,* technically, injunctive relief is only available against officials in their individual capacity; however, courts have gradually approached this fiction more leniently and permitted claims against state officials acting solely in their official capacity.

The principle enunciated in *Ex Parte Young,* permitting suits for injunctive relief against state officials who violate federal constitutional rights, has been expanded to apply to violations of federal statutes as well. *See Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 96 n. 14 (1983); *Almond Hill School v. United States Dept. of Agric.,* 768 F.2d 1030, 1034 (9th Cir. 1985); *Allegheny County Sanitary Auth. v. United States Envtl. Protection Agency,* 732 F.2d 1167, 1174 (3d Cir. 1984).

Moreover, declaratory relief, ancillary to injunctive relief, against a state official is not barred by the Eleventh Amendment. *Green v. Mansour,* 474 U.S. 64, 72-73 (1985), *reh'g denied,* 474 U.S. 1111 (1986); *Lee v. Western Reserve Psychiatric Habilitation Center,* 747 F.2d 1062, 1066 (6th Cir. 1984).

Although it appears that much of the challenged conduct may have occurred prior to defendant Maleski's tenure on the Commission, the prospective nature of the relief which Plaintiffs seek clearly implicates her as she is the individual charged with carrying out the disputed conduct. Moreover, "personal action by defendants individually is not a necessary condition of injunctive relief against state officers in their official capacity. All that is required is that the official be responsible for the chal-

lenged action." *Luckey v. Harris,* 860 F.2d 1012, 1015 (11th Cir. 1988).

Because the Eleventh Amendment does not preclude Plaintiffs from seeking injunctive or declaratory relief against defendant Maleski, this court's subject matter jurisdiction over her is not defeated by the Eleventh Amendment.

II. Dismissal under Rule 12(b)(6)

A Rule 12(b)(6) motion tests the legal foundation of the plaintiff's claims; it is not intended to question the plaintiff's facts. *United States v. Marisol, Inc.,* 725 F. Supp. 833, 836 (M.D. Pa. 1989). The court must determine if the plaintiff's claim would fail even if all facts alleged in the complaint were true. *Mortensen v. First Fed. Sav. & Loan Ass'n,* 549 F.2d 884, 891 (3d Cir. 1977); *Conley v. Gibbons,* 355 U.S. 41, 45-46 (1957). The 12(b)(6) movant carries the burden of showing this legal insufficiency of the claims asserted. *Johnsrud v. Carter,* 620 F.2d 29, 33 (3d Cir. 1980).

To prevent unwarranted dismissal of the plaintiff's claims, the allegations put forth in the complaint are taken as true and inferences from those facts are viewed in the light most favorable to the plaintiff. *Mortensen,* 549 F.2d at 891; *Truhe v. Rupell,* 641 F. Supp. 57, 58 (M.D. Pa. 1985). However, "conclusory allegations of law, unsupported conclusions and unwarranted inferences need not be accepted as true." *Pennsylvania House, Inc. v. Barrett,* 760 F. Supp. 439, 449-50 (M.D. Pa. 1991) (citing *Conley,* 355 U.S. at 45-46). A Rule 12(b)(6) motion will be granted only if "it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson,* 355 U.S. at 45-46.

III. ERISA preemption

A. Introduction

The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, regulates a broad range of employee plans: As one court has described:

> Congress enacted ERISA to protect working men and women from abuses in the administration and investment of private retirement plans and employee welfare plans. Broadly stated, ERISA established minimum standards for vesting of benefits, funding of benefits, carrying out fiduciary responsibilities, reporting to the government and making disclosures to participants.

Donovan v. Dillingham, 688 F.2d 1367, 1370 (11th Cir. 1982).

To help achieve these goals, Congress provided for federal preemption over state laws regulating specified employee benefit and welfare plans by mandating that ERISA shall "supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a). However, to maintain states' traditional role in regulating the insurance industry, Congress limited the scope of this preemption by providing that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A).

To ensure that this savings clause is not used in so broad a manner as to defeat the purpose of ERISA, § 1144(b)(2)(B) (also known as the "deemer clause") provides that no employee benefit plan:

> shall be *deemed* to be an insurance company or other insurer, bank trust company, or investment company or to be engaged in the business of insurance or

> banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B). Thus, this provision safeguards against the possibility that states will bypass federal preemption under ERISA by merely claiming that particular plans are insurers.

Preemption by ERISA law has a broad reach. It encompasses all laws, decisions or regulations of:

> a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

29 U.S.C. § 1144(c)(2).

B. Form of Analysis

There are several steps in determining whether ERISA preempts state regulation of Atlantic. First, the court must decide if Plaintiffs' plan is an "employee benefit plan" within ERISA's definition of that term. Plaintiff provides two alternative rationales that it is: either (1) Plaintiff merely oversees a trust to which individual employees contribute as part of their *own individual employee benefit plans* and thus, the trust is just a consolidation of parts of these plans making it a plan, or (2) it is a plan administered by an employer group. If Plaintiffs do not have an employee benefit plant, then ERISA does not apply and state regulation is permitted. If the plan is an employee benefit plan, then the court must decide if it is a multiple employer welfare arrangement of the type which may be regulated by the state.

C. Is Atlantic a trust established under an employee benefit plan?

Plaintiffs assert that they have established a trust to which individual employers contribute as part of their individually maintained employee benefit plans covered by ERISA. They contend that, assuming Atlantic is itself not an employee benefit plan under ERISA, in the alternative, it is a trust established under such a plan.

This argument is untenable. Plaintiffs are trying to weasel themselves into the ERISA domain by creatively labeling their enterprise. Their project already has a definition: a multiple employer welfare arrangement ("MEWA"). 29 U.S.C. § 1002(40)(A) provides:

> The term 'multiple employer welfare arrangement' means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) (29 U.S.C. § 1002(1)) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—
>
> > (i) under or pursuant to one or more agreements which the Secretary (of Labor) finds to be collective bargaining agreements, or
> >
> > (ii) by a rural electric cooperative.

29 U.S.C. § 1002(40)(A). Moreover, all assets of an employee benefit plan must be deposited in a trust. 29 U.S.C. § 1103(a).[2] Thus, what Plaintiffs in actuality administer is a trust which is part of a MEWA.

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[2] Plaintiff makes no argument that any of the exceptions to this requirement are applicable in the captioned case. *See* 29 U.S.C. § 1103(b).

Plaintiffs unpersuasively cite to a statutory section forbidding a state from regulating an employee welfare benefit plan which is not a multiple employer welfare arrangement ("MEWA") but which uses a MEWA to administer its benefits. 29 U.S.C. § 1144(b)(6)(C).[3] However, Plaintiff has not shown that the numerous single-employer plans over which it claims to be a fiduciary are employee benefit plans under ERISA. *See generally MDPhysicians & Associates v. State Bd. of Ins.*, 957 F.2d 178, 182 n.4 (1992) and cases cited therein; *Credit Managers Ass'n v. Kennesaw Life and Accident Ins. Co.*, 809 F.2d 617, 625-26 (9th Cir. 1987). More importantly, this section prevents *individual* employee benefit plans, covered by ERISA, from being state regulated merely because they utilize a MEWA in obtaining benefits; however, the section *does not* provide immunity to MEWAs themselves from state regulation.

Therefore, Plaintiffs' remaining question is whether this MEWA is or is not an employee benefit plan within the reach of ERISA.

D. Is Plaintiffs' plan an ERISA covered Employee Benefit Plan?

ERISA covers three types of employee benefit plans: (1) employee welfare benefit plans—providing health, hospitalization, and disability benefits, (2) employee pension benefit plans—providing retirement or deferred income, or (3) plans which provide both. 29 U.S.C. § 1002. Plaintiffs claim that its plan falls within the first category—an employee welfare benefit plan. Defendants vigorously refute this claim.

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[3] That section provides that nothing: "shall affect the manner or the extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a MEWA and which is a plan, fund, or program participating in, subscribing to, or otherwise using a MEWA to fund or administer benefits to such plan's participants and beneficiaries." 29 U.S.C. § 1144(b)(6)(C).

Section 1002 defines an employee welfare benefit plan as:

> any plan, fund, or program which was heretofore or is hereafter *established or maintained by an employer* or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services. . . .

29 U.S.C. § 1002(1) (emphasis added). Thus, an ERISA employee welfare benefit plan must be:

> (1) a 'plan or fund or program'
>
> (2) established or maintained
>
> (3) by an employer or by an employee organization, or by both,
>
> (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death [and other benefits not relevant here]
>
> (5) to participants or their beneficiaries.

Donovan, 688 F.2d at 1371.[4] The parties do not appear to dispute that Plaintiffs' plan meets three of the criteria:

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[4] The Commonwealth Court in this state has offered a different framework for determining whether a particular plan is covered by ERISA; a covered employee benefit plan has five characteristics:

> (a) it was provided by an employer or homogeneous employee organization, such as a union;
>
> (b) it was non-commercial in nature;
>
> (c) it did not involve solicitation;
>
> (d) it was not intended to be actuarially sound;

(1) it is a fund, (2) it does provide benefits, (3) to employees of participating employers. The remaining two criteria—whether an employer or employer organization established or maintained the plan at issue—is the focus of the disagreement between the two parties.

ERISA is applicable to:

> any employee benefit plan if it is *established or maintained*—
>
> > (1) by any employer engaged in commerce or in any industry or activity affecting commerce. . . .[5]

29 U.S.C. § 1003(a) (emphasis added). Moreover, ERISA provides the following definition of employer as:

> any person acting directly as an employer, or *indirectly in the interest of an employer*, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. § 1002(5) (emphasis added). Thus, to fall within ERISA, Plaintiffs' plan must either be established

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(e) because the employers could look only to the fund, and not to the provider of that fund, the rates were substantially lower than insurance rates.

Foster v. West Branch Administrators, 597 A.2d 721, 724 (Pa. Commw. 1991) (citing *Bell v. Employee Security Benefit Ass'n*, 437 F. Supp. 382, 391 (D. Kan. 1977)). However, as *Foster's* first characteristic—involvement of an employer—is analogous to the "employer" prong of *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), and as analysis herein will focus only on this prong, other characteristics set forth in *Foster* need not be considered.

[5] The statute also provides that a plan can be maintained by an employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; however, these sections are inapplicable to the case at bar.

or maintained by either an employer or an association acting in the interests of employers.

The record contains no indication that Atlantic acted as an employer to the employees who benefitted from the plan. Nor are there any facts to demonstrate that employers *established* the plan.[6]

Thus, for ERISA to apply, Atlantic must be maintained by an employer group acting in the interest of the employers. In analyzing this issue, it is important to distinguish between two different types of plans: (1) individual employers' plans which obtain benefits from a MEWA, and (2) the MEWA itself. The former is not at issue in the captioned action, as there is no apparent dispute between the Commonwealth and any of the individual employers who participate in Plaintiffs' plan. Thus, the court must determine whether the MEWA itself is an employee benefit plan.

Courts have tended to examine two important characteristics in determining whether a particular organization is acting in the interests of the employer so as to bring its plan within the scope of ERISA.

First, involvement of the individual participating employers in the administration of the plan helps to demonstrate that the plan administration is acting in the best interests of the employers. As one court has explained, "To allow an entrepreneurial venture to qualify as an 'employer' by establishing and maintaining a multiple employer welfare arrangement without input by the employers who subscribe to the plan would twist the language of the statute and defeat the purposes of Congress." *MDPhysicians & Assoc., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 185 (5th Cir. 1992), *cert. denied* —— U.S. ——, 113 S. Ct. 179 (1992). Moreover, an employer association "cannot possibly act in the interest of employ-

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[6] There is the argument to this effect which is rejected above by the court.

ers when such employers have no voice in the management or operation of the plan because no basis for an agency relationship exist." *MDPhysicians, Inc. v. Wrotenbery*, 762 F. Supp. 695, 698 (N.D. Tex. 1991), *aff'd*, 957 F.2d 178 (5th Cir. 1992), *cert. denied*, —— U.S. ——, 113 S. Ct. 179 (1992) (citations omitted).

A multi-employer plan is not within the ambit of ERISA if employers have no day-to-day involvement in its administration, *Taggart Corp. v. Life Health Benefits Admin. Inc.*, 617 F.2d 1208, 1210 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981);[7] if the employer group has but a "minimal, ministerial" role, *Otto v. Variable Annuity Life Ins. Co.*, 814 F.2d 1127, 1135 (7th Cir. 1986), *cert. denied*, 486 U.S. 1026 (1988); if the employer merely advertises the plan and collects contributions, *id.*; or if a multiple employer trust acts as "mere conduit" for subscribers, *Taggart* at 1210. *See also Bell v. Employee Sec. Ben. Ass'n*, 437 F. Supp. 382, 392-93 (D.C. Kan. 1977) (not ERISA plan since insufficient involvement by employee group); *Hamberlin v. VIP Ins. Trust*, 434 F. Supp. 1196, 1198 (D. Ariz. 1977) (not ERISA plan since employers did not participate in administration of plan nor contribute to it); *Matthew 25 Ministries, Inc. v. Corcoran*, 771 F.2d 21, 22 (2d Cir. 1985) (the employers played "no role in the management of the trust,"); *Baucom v. Pilot Life Ins. Co.*, 674

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[7] Plaintiffs assert that *Taggart* was wrongly decided as evidenced by criticism of it by *Donovan v. Dillingham*, 688 F.2d 1367, 1375 (1982). *Donovan*, however, did not reject the holding nor the reasoning of *Taggart*. Rather, the former case offered a limiting interpretation of the latter. Specifically, *Donovan* agreed with *Taggart* that a multi-employer trust from which employers merely purchase insurance is not an employee welfare benefit plan under ERISA. However, *Donovan* went on to criticize any reading of *Taggart* which would preclude finding that an individual employer's plan, which is part of a multi-employer trust, is an employee welfare benefit plan under ERISA. The question of whether individual employers' plans, providing coverage through Atlantic, are within the scope of ERISA is not before this court.

F. Supp. 1175, 1181 (M.D.N.C. 1987) (no active involvement of employers in plan's founding or administration").[8] Note, however, that a mere ministerial involvement *may* be sufficient to bring an employer's *individual* plan within the scope of ERISA although the same conduct will not bring a multi-employer trust into the scope of ERISA. *See, e.g., Credit Managers Ass'n,* 809 F.2d at 625; *Memorial Hosp. System v. Northbrook Life Ins. Co.,* 904 F.2d 236, 242-43 (5th Cir. 1990) (employer's role minimal but sufficient to demonstrate that its purchase of benefits from a multi-employer trust was covered by ERISA; the issue was not, however, whether the trust was covered by ERISA).

Second, many cases have required some cohesive bond between the employers, other than their common participipation in the disputed plan, to help ensure that the plan administration is acting in the best interest of the employers. As one court has explained:

> The definition of an employee welfare benefit plan is grounded on the premise that the entity that maintains the plan and the individuals that benefit from the plan are *tied by a common economic or representation interest, unrelated to the provisions of benefits.* . . . [A] relationship [without such ties] is similar to the relationship between a private insurance company, which is subject to myriad state insurance regulations, and the beneficiaries of a group insurance plan.

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[8] *But see Kanne v. Connecticut Gen'l Life Ins. Co.,* 867 F.2d 489, 492 (9th Cir. 1988), *cert. denied,* 492 U.S. 906 (1989) (ERISA plan even though employer's function only "minor and ministerial."). However, the multi-employer trust in *Kanne* was administered by an employer group—the Associated Builders and Contractors of which the planntiff's employer, a carpet manufacturer, was a member. Thus, it appears that the plan was characterized by a certain commonality of the employers—being in the same field of business. In contrast, there is no evidence that the employers comprising plaintiff United Health Care Association are similarly associated.

Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd. of Public Instruction, 804 F.2d 1059, 1063 (8th Cir. 1986) (emphasis added). Participating employers should not be "disparate and unaffiliated," *Matthew 25 Ministries, Inc.,* 771 F.2d at 22, but should be linked by some common interest. As the court in *MDPhysicians & Associates, Inc. v. State Bd. of Ins.* has stated:

> The most common example is the economic relationship between employees and a person acting directly as their employer. *See Hansen* [*v. Continental Ins. Co.*], 940 F.2d 971, 978 [(5th Cir. 1991)]. The representational link between employees and an association of employers in the same industry who establish a trust for the benefit of those employees also supplies the requisite connection. *See National Business Ass'n Trust v. Morgan,* 770 F. Supp. 1169, 1174-75 (W.D. Ky. 1991) . . . This special relationship protects the employee, who can rely on the 'person acting directly as an employer' or the person 'acting indirectly in the interests of' that employer to represent the employee's interest relating to the provision of benefits. *Cf. Wisconsin Educ. Ass'n,* 804 F.2d at 1063.

MDPhysicians & Associates, Inc. v. State Bd. of Ins., 957 F.2d at 186. *See also Bell,* 437 F. Supp. at 392-93 (not ERISA plan since insufficient commonality of employees); *Baucom,* 674 F. Supp. at 1179-1180 (same); *Nat'l Business Conf. Employee Benefits Ass'n v. Anderson,* 451 F. Supp. 458, 461 (S.D. Iowa 1977) (employees must have common interest in employment relationship for ERISA plan).

In the captioned case, there is no indication that Atlantic is characterized by either of these two elements. There is no evidence that the employers who comprise defendant United Healthcare Association have participated in either the establishment or the administration of the Atlantic trust in any way but in merely submitting the monthly payments due. Moreover, it does not appear

that the members of United Health Care Association are related in any way other than similarly subscribing to Atlantic's benefit plan.

Nonetheless, as the motion before this court is one to dismiss, not one for summary judgment, and since there are few to no facts before this court on which to determine the exact characteristics of the Atlantic plan, the court is unable to determine whether Atlantic constitutes an employee benefit plan within the ambit of ERISA. However, this obstacle does not preclude disposition of the motion at issue.

E. Is Plaintiffs' plan an ERISA covered Multiple Employer Welfare Arrangement?

Since there are insufficient facts to determine whether Atlantic is an ERISA plan, the court will assume *for purposes of this motion* that Atlantic is an employee benefit plan covered by ERISA. Moreover, the court has already determined at "III(C)" that Atlantic is not "just" a trust but is a MEWA. Thus, the final question is whether Atlantic is a non-fully insured multiple employer welfare arrangement thereby permitting state regulation which is not inconsistent with ERISA reqirements.

Congress amended the preemption language of ERISA to permit limited state regulation of MEWA's under state insurance law:

> Notwithstanding any other provision of this section—
>
> . . .
>
> (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, *any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.*[9]

29 U.S.C. § 1144(b)(6)(A) (emphasis added).

[9] (i) is inapplicable as Atlantic is not fully insured.

Thus, state regulation of MEWA's is permitted as long as the regulations are not inconsistent with ERISA. Plaintiffs assert that the challenged regulations *are* inconsistent with ERISA, or, in the alternative that permissible state regulations must explictily mention application to MEWAs. Neither of these arguments are persuasive.

1. Are Defendants' proposed regulations to Plaintiffs' plan inconsistent with those provided by ERISA?

Plaintiffs assert that the laws which Defendants seek to apply to them are inconsistent with ERISA. However, requiring a plan to obtain a state license has been held *not to be inconsistent* with the provisions of ERISA. The court in *MDPhysicians, Inc. v. Wrotenbery* determined that Texas licensing provisions applied to a MEWA, finding that:

> The Texas requirement that the MDP Plan apply for a certificate of authority to conduct business in the state of Texas is not inconsistent with ERISA's requirement that an ERISA plan file with the Secretary of Labor, a plan description, modifications, annual reports and supplemental reports, as required in 29 U.S.C. § 1021(b)

Wrotenbery, 762 F. Supp. at 699. *See also National Business Ass'n Trust*, 770 F. Supp. at 1169 (MEWA not exempt from the state's licensure requirements since consistent with 29 U.S.C. § 1144(b)(6)(A)(ii)).

2. MEWA-specific legislation

Plaintiffs assert that due process requires that the ERISA exception allowing state regulation of MEWAs only applies to state laws that specifically address MEWAs.

Title 29 U.S.C. § 1144(b)(6)(A)(ii) specifically provides that MEWAs are subject to "*any law* of any State

which regulates insurance." The MEWA exception nowhere limits the state to MEWA-specific laws. *See Wrotenbery,* 762 F. Supp. at 699 (MEWA subject to Texas' general (not MEWA-specific) insurance licensing law).

Conclusion

The record before the court is inadequate to determine whether or not the Atlantic plan is an employee welfare benefit plan. It appears (1) that employers did not establish the plan; (2) that they only minimally participate in the administration of the plan; and (3) that they are not linked by any common interest other than participation in the plan. However, insufficient evidence has been submitted to satisfactorily resolve the issue of whether ERISA is applicable to Atlantic.

However, even if Plaintiffs provide a covered employee benefit plan, it is a MEWA which may be regulated by state laws not inconsistent with ERISA; a state licensing scheme is not inconsistent with ERISA. Obviously, if Atlantic is not covered by ERISA, it may be regulated by the Commonwealth.

Therefore, whether or not Atlantic is an employee benefit plan, the state's requirement that it obtain a license is not precluded by ERISA. Defendants' motion to dismiss Plaintiffs' complaint will be granted. An appropriate order will follow.

/s/ Sylvia H. Rambo
SYLVIA H. RAMBO
Chief Judge
Middle District of Pennsylvania

Dated: December 23, 1992.

APPENDIX C

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

Docket No. P91-05-45

IN RE: ATLANTIC HEALTHCARE BENEFITS TRUST
2914 High Street,
Portsmouth, VA 23701

and

UNITED HEALTHCARE ASSOCIATION OF AMERICA
2914 High Street
Portsmouth, VA 23701

and

NATIONAL INSURANCE CONSULTANTS, INC.
2914 High Street
Portsmouth, VA 23701

and

EDWARD M. ZINNER
2914 High Street
Portsmouth, VA 23701

and

WILLIAM E. MOULTON
2914 High Street
Portsmouth, VA 23701

Respondents

ALLEGED VIOLATIONS: Sections 208, 209, 603, 605, 606, 621, 622, 623, 631, and 639 of the Insurance Department Act, Act of May 17, 1921, P.L. 789, *as amended,* 40 P.S. §§ 46, 47, 233, 235, 236, 251, 252, 253, 271, and 279; and Sections 3, 7, 10, 11, 12, and 13 of the Act of January 24, 1966, P.L. 1509, *as amended,* 40 P.S. §§ 1006.3, 1006.7, 1006.10, 1006.11, 1006.12, and 1006.13.

Sections 4, 5(a), 7(ii), 8 and 9 of the Unfair Insurance Practices Act of 1978, Act of July 22, 1974, P.L. 589 (40 P.S. §§ 1171.4 and 1171.5(a), 7(ii), 1171.8 and 1171.9).

OPINION AND ORDER

AND NOW, this 27th day of November, 1991, Constance B. Foster, Insurance Commissioner of the Commonwealth of Pennsylvania, hereby issues the following Opinion and Order.

HISTORY

On June 28, 1991, the Insurance Department issued an Order to Show Cause against Atlantic Healthcare Benefits Trust ("Atlantic"), United Healthcare Association of America, National Insurance Consultants, Edward M. Zinner and William E. Moulton (hereafter referred to collecitvely as "Respondents"). Respondents answered the Order to Show Cause on July 29, 1991. On August 23, 1991, the Insurance Department filed a Motion for Summary Judgment, which was amended on September 26, 1991. Respondents answered both the Motion and the Amended Motion and both parties submitted briefs on an expedited schedule. This matter now stands ready for a determination.

FINDINGS OF FACT

1. Atlantic Healthcare Benefits Trust is a foreign trust organized under the laws of the Commonwealth of Virginia.

2. United Association of America is an association with members representing the entire spectrum of the business, professional and industrial communities of the United States.

3. National Insurance Consultants, Inc. is a foreign corporation that markets and administers certain health and medical benefit plans for United Healthcare Association of America and Atlantic Healthcare Benefits Trust.

4. Edward M. Zinner is the President of National Insurance Consultants, Inc.

5. William Moulton is a co-director of United Healthcare Association of America and the President of United Healthcare Association of America.

6. Atlantic Healthcare Benefits Trust (Atlantic) is not licensed as an insurer in Pennsylvania.

7. By and through agents, brokers and others, Atlantic has solicited, and continues to solicit, licensed individuals and entities for the purpose of selling certain health and medical benefit plans to residents of Pennsylvania.

8. Atlantic supplied Pennsylvania agents with information about Atlantic to be used in soliciting Pennsylvania residents to become subscribers to the trust.

9. Atlantic obtains subscribers through Pennsylvania agents who are paid commissions and/or fees.

10. Atlantic currently offers health and medical benefits to Pennsylvania residents.

11. Atlantic bills and collects premiums and administrative fees.

12. Atlantic has not paid premium or surplus lines taxes to the Pennsylvania Department of Revenue.

13. On or about February 14, 1991, Jeff Woodmyer and Jim Dixon, of Baumillers, a screw manufacturing/ machinst shop operated as a sole proprietorship in Glenn Rock, Pennsylvania, were solicited and sold a benefits plan by insurance agent Charles Zimmerman on behalf of Atlantic.

14. Baumillers paid the premium with check number 1734 dated February 14, 1991 in the amount of $764, payable to Atlantic.

15. Zimmerman presented Baumillers with a document outlining Atlantic's benefit plan.

16. On or about February 19, 1991, Robin Albanese of Dominic Albanese Electrical and Mechanical, located in West Easton, Pennsylvania, was solicited and sold a health and benefit plan by insurance agent Robert Ziff, on behalf of Atlantic.

17. Albanese paid the premium with check number 159, dated February 19, 1991, in the amount of $301, payable to National Insurance Consultants.

18. Ziff provided Albanese with a brochure outlining the benefits provided by Atlantic Healthcare Benefits Plan.

19. On February 5, 1991, Brian L. Reigart, D.D.S., provided a second premium payment to insurance agent Zimmerman by check number 2941 in the amount of $365 payable to "UHCAA."

20. Faith and Craig Peterson of York Adams Mobilcare, Inc., located in Abbotstown, Pennsylvania, paid Atlantic a premium with check number 1546 dated February 1, 1991, in the amount of $296.60, payable to United Healthcare Association of America.

21. Agent Zimmerman present the Petersons with a document outlining the benefits provided by Atlantic Healthcare Benefits Plan.

22. On or about February 2, 1991, Charles and Rose Ann Fox of Skyview Satellite Service, located in Red Hill, Pennsylvania, were solicited and sold a health and medical plan by insurance agent Robert Ziff, on behalf of Atlantic.

23. The Foxes made a premium payment in the amount of $336 by check number 1101 dated February 2, 1991, payable to U.H.C.A./NICI.

24. On or about February 15, 1991, Joseph Ruffino of La Trattoria Siciliano, located in Old Zionville, Pennsylvania, was solicited and sold a health and medical plan by insurance agent Ray Hilgreen, Sr., on behalf of Atlantic.

25. Ruffino paid the premium with check number 1503 payable to "N.I.C.I." in the amount of $335.

26. Hilgreen provided Ruffino with a document outlining the benefits provided by Atlantic Healthcare Benefits Plan.

27. On or about February 23, 1991, Verna D. Yost of Yost Family Enterprises, in Christiana, Pennsylvania, was solicited and sold a health and medical benefits plan by insurance agent Charles Hershey, on behalf of Atlantic.

28. Yost paid the premiums by checks numbered 436 and 437 in the amounts of $797 and $617 made payable to "N.I.C.I."

29. Yost received a document outlining the benefits provided by Atlantic Healthcare Benefits Plan.

30. Atlantic does not provide its subscribers insurance coverage through an insurer licensed to do business in this Commonwealth.

31. On or about May 13, 1991, the Insurance Commisisoner for the State of Delaware issued a cease and desist order against National Insurance Consultants and

Atlantic to prohibit them from further illegal transaction of the insurance business in that state.

32. On or about April 15, 1991, the Kentucky Department of Insurance initiated an action against Respondents, which was resolved by an Agreed Order dated June 10, 1991.

33. On March 30, 1991, the State of Maryland issued a cease and desist order against Atlantic.

34. If any of the foregoing Findings of Fact are found to constitute Conclusions of Law, the ones so found are incorporated therein by reference.

DISCUSSION

The Insurance Department seeks summary judgment and the imposition of civil penalties against Respondents for engaging in unlicensed insurance activities in Pennsylvania. Respondents contend that their activities do not constitute the business of insurance but are permissible activities under the Employee Retirement Security Act of 1974, *as amended,* P.L. No. 93-406, 88 Stat. 829, 29 USC § 1001, *et seq.,* (ERISA). The facts regarding the conduct of Respondents are not disputed. The intertwined issues presented are: (1) does ERISA preempt Pennsylvania's insurance statutes with respect to Respondents? and (2) are Respondents engaged in the business of insurance in Pennsylvania? If Respondents are not ERISA exempt, and are engaged in the business of insurance, they are in violation of Pennsylvania's insurance laws and may be subject to civil penalties for unlicensed, illegal activity.

ERISA

In 1974, Congress enacted ERISA to establish certain minimum standards, assure the equitable character of employee benefit plans, and to assure the plans' financial soundness in response to certain abuses which had re-

sulted in loss of benefits to employees. 29 U.S.C. § 1011(a). *Sayble v. Blue Cross of Southern California,* 255 Cal. Rptr. 144 (Cal. App. 1989). For ERISA purposes, "employee benefit plan" refers to an employee welfare benefit plan (providing health, hospitalization, and disability benefits) or an employee pension benefit plan (providing retirement income or deferred income) or a plan which is both. 29 U.S.C. § 1002(3). Respondents claim to fall within the first type of plan.

An "employee welfare benefit plan" is defined as follows:

> (1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or pre-paid legal services. . . .

29 U.S.C. § 1002(a)(1).

The definition of employee welfare benefit plan is "grounded on the premise that the entity that maintains the plan and the individuals that benefit from the plan are tied by a common economic or representation interest, unrelated to the provision of benefits." *Wisconsin Education Association Insurance Trust v. Iowa State Board of Public Instruction,* 804 F.2d 1059, 1063 (8th Cir. 1986).

To protect employers from conflicting state regulation of employee benefit plans, ERISA contains a broad pre-

emption of state law. The preemption provision reads as follows:

> (a) Supersedure; effective date.
>
> Except as otherwise provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) or this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.
>
> (b) Construction and application.
>
> * * * *
>
> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.
>
> (B) Neither an employee benefit plan described in section 1003(b) of this title (other than a plan estalished primarily for the purpose of providing death benefits), or any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144. Prior to resolving the issue of the application of the supersedeas provision, it is first necessary to determine whether Respondents established or are maintaining an employee benefit plan that meets ERISA requirements.

The definition of "employee benefit plan" is composed of five parts. There must be (1) a plan or fund or program (2) established or maintained (3) by an employers or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death and other benefits not relevant here (5) to participants or their beneficiaries. *Donovan v. Dillinger,* 688 F.2d 1367, 1371 (11th Cir. 1982). In a recent decision, the Commonwealth Court followed the criteria used by the federal court in *Bell v. Employee Security Benefit Association,* 437 F.Supp. 382, 391 (D. Kan. 1977) to evaluate whether an entity was in fact an ERISA exempt employee benefit plan:

> (1) it was provided by an employer or homogeneous employee organization, such as a union; (b) it was non-commercial in nature; (c) it did not involve solicitation; (d) it was not intended to be actuarially sound; (e) because the employers could look only to the fund, and not to the provider of that fund, the rates were substantially lower than insurance rates.

Foster v. West Branch Administrators, —— Pa. Commonwealth Ct. ——, —— A.2d —— (1991) (Slip Opinion at 5-6).

Utilizing the above referenced criteria, the Commissioner finds that the Respondents do not constitute an employee welfare benefit plan. First and foremost, the plan was neither established nor maintained by employers or an homogeneous employee organization. The plan was created by two businessmen, Edward Zinner and William Moulton, as a for-profit enterprise. Zinner and Moulton are not employers or representatives of an employee organization, but are in fact entrepreneurs, who created Atlantic Healthcare Benefits Trust and its administrator, National Insurance Consultants, Inc. and who solicit and equip an agency force to market coverage through the trust. Second, the benefits system set up by Respondents

is commercial in nature. Third, the plan involves solicitation of unrelated employers by an agency force that is paid commissions. Thus, Respondents do not meet three of the five criteria.

The fund at issue resembles the health care plans found not to be ERISA exempt in *Taggert Corporation v. Life and Health Benefits Administration Plan, Inc.*, 617 F.2d 1208 (5th Cir. 1980) and *Plotkin v. Association of Eye Care Centers, Inc.*, 710 F. Supp. 156 (ED NC 1989). Both cases involved a trust which provided group insurance for employers too small to qualify for group rates on their own. The trust in each case was a proprietary enterprise, established and operated by independent businessmen for their own personal profit and served as "a mere conduit" for premiums from hundreds of unrelated consumers to be forwarded to a group insurer. No employer participated in the trusts' day to day administration and operation. It appears from the record presented that Respondents' operation falls into this category of non-exempt plans. As stated, Atlantic is the entrepreneurial enterprise of Messrs. Zinner and Moulton. The subscribing employers are ostensibly members of United Healthcare Association of America, however, they do not qualify as a "group or association" within the definition of "employer" set forth in ERISA. It appears the employers lack any real authority over the trust. Authority over the trust rests with National Insurance Consultants, Inc., controlled by the same individuals who established the alleged "association" of unrelated employers and the trust. Because the employers lack any power in substance over the management of the trust, Respondents' operations fail to qualify as an ERISA employer welfare benefit plan, and are thus not exempt from state regulation.

RESPONDENTS ARE SUBJECT TO STATE INSURANCE REGULATION AS A MULTIPLE EMPLOYER WELFARE ARRANGEMENT (MEWA)

ERISA defines the term "multiple employer welfare arrangement" as follows:

> . . . an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries except that such term does not include any such plan or other arrangement which is established or maintained—
>
> (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, or
>
> (ii) by a rural electric cooperative.

29 U.S.C. § 1002(40)(A). The MEWA definition also provides that two or more businesses will be considered one employer if they are under common control. 29 U.S.C. § 1002(40)(B).

ERISA was amended to expressly permit state regulations of MEWA's in order to curb abuses by Multiple Employer Trusts (METS). The preemptive effect of ERISA on state regulation of MEWAs was modified in 1983:

> (A) Notwithstanding any other provision of this section—
>
> (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which reg-

ulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, *any law which regulates insurance may apply* to the extent not inconsistent with the preceding sections of this title.

29 U.S.C. § 1144(b)(6)(A) (Emphasis added). Because Atlantic is not a fully insured MEWA, Subsection (i) does not apply. Recent federal decisions interpreting subsection (ii), which applies to Respondents, have concluded that MEWAs are not "automatically" exempt from state law under ERISA. A MEWA that is also an employee welfare benefit plan may be exempted by ERISA, but a MEWA that is *not* an employee welfare benefit plan is subject to state law. See *Eddy v. John Alden Life Insurance Company,* 1991 U.S. Dist. LEXIS 3717 (1991).

The conclusion that uninsured MEWA's are subject to state regulation is reinforced by the United States Department of Labor's August 16, 1991 letter which conveyed its opinion that Atlantic Healthcare Benefits Trust is a MEWA subject to Pennsylvania regulations. (Motion for Summary Judgment, Exhibit D). The opinion letter explains that although Section 514(b)(6)(b)[1] allows the

[1] Section 514(b)(6)(B) provides in part:

The Secretary may, under regulations which may be prescribed by the Secretary, exemption from Subparagraph (A)(ii), individually or by class, multiple employee welfare arrangements which are not fully insured . . .

Secretary of Labor to exempt employee benefit plans which are MEWA's from state regulation, no exemption by regulation has occurred. The Department of Labor concludes:

> It is therefore, the Department's position that the preemption provisions of ERISA do not preclude state regulation of the Trust at least to the extent provided in Section 514(b)(6)(A), regardless of whether it is an employee benefit plan covered by Title 1 of ERISA, because it is a MEWA within the meaning of Section 3(40) of that title.

(Motion for Summary Judgment, Exhibit D at page 3).

The Commissioner finds that Respondents are neither an insured MEWA or an employee welfare benefit plan and are therefore subject to Pennsylvania's insurance laws if they are doing insurance business in the state.

RESPONDENTS ARE ENGAGING IN THE BUSINESS OF INSURANCE

Insurance is a contract by which one party for consideration promises to make a certain payment of money upon the destruction or injury of something in which the other party has an interest. *Couch on Insurance* 2d, § 1:2. Characteristic of insurance is the acceptance of a number of risks and the spreading of losses to all the risks to allow the insurer to accept the risk at a fraction of the possible liability upon it. *Couch, supra,* § 1:3.

Respondents' trust plan is clearly insurance. Subscribers pay a monthly premium to Atlantic through National Insurance Consultants or United Healthcare Association of America and receive health benefits and reimbursement for medical expenses. The risk of loss is spread among a number of subscribers; subscribers pay premiums which are only a fraction of the potential losses.

Respondents market the trust in a manner similar to insurance. Subscribers are solicited by agents who earn

commissions on the premiums collected. Brochures refer to the subscribers' payments for medical expenses as "premiums." The subscribers submit claims and payment is made on those claims by Atlantic in accordance with its benefits plan booklet.

From a review of the trust's operations, it is clear that the trust, through its administrators, is soliciting insureds and offering accident and health benefits, paying commissions to outside agents, and pooling premiums. These activities constitute "doing insurance" in Pennsylvania, as set forth in Section 208 of the Insurance Department Act of 1921, *as amended*:

> (b) Any of the following acts constitute the doing of an insurance business within this Commonwealth, or whether effected by mail or otherwise:
>
> (1) the issuance or delivery of contracts of insurance to persons resident in this Commonwealth, or
>
> (2) the solicitation of applications for such contracts, or other negotiations preliminary to execution of such contracts, or
>
> (3) the collection of premiums, membership fees, assessments, or other consideration for such contracts, or
>
> (4) the transaction of matters subsequent to execution of such contracts and arising out of them.

40 P.S. § 46.

Respondents present the creative argument that they are not required to comply with Pennsylvania's insurance laws because they are a MEWA and Pennsylvania has no statute governing MEWA's. Likewise, Respondents assert they are not subject to Insurance Department regulation because there is no statute governing trusts that offer health and medical benefits.

The Commissioner rejects Respondents' "lack of statutory authority" argument. An illegal insurer cannot escape regulation or sanctions by virtue of the fact it is not organized as a corporation, association, or exchange, the types of entities contemplated by the insurance statutes. The Department correctly cites Section 106 of the Insurance Deparment Act which requires compliance with the Act:

> It shall be unlawful for any person, company, association, exchange, copartnership, or corporation to negotiate or solicit, within this Commonwealth, any contract of insurance, or to effect the same, or to receive and transmit any offer or offers of insurance, or receive or deliver a policy or policies of insurance, or in any manner to aid in the transaction of the business of insurance, without fully complying with the provisions of this act.

40 P.S. § 26.

Respondents admit that they have not complied with Pennsylvania law. The trust does not hold a certificate of authority to do business (40 P.S. § 46). Neither National Insurance Consultants, Inc. nor United Healthcare Association of America are licensed to place risks with the trust as agents (40 P.S. § 233) or brokers (40 P.S. § 252). No surplus lines approval has been obtained (40 P.S. § 1006.7) and no surplus lines tax paid (40 P.S. § 1006.20). The conduct of Respondents in promoting and soliciting for an unlicensed insurer exposes them to personal liability on all risks placed with the trust (40 P.S. § 235) based on their prohibited conduct of acting as agents for an unlicensed insurer (40 P.S. § 1007.3) and advertising as an agent of an unlicensed company (40 P.S. § 236). The Department also cites Respondents for failure to comply with the contract requirements of the surplus lines law which warns insureds that coverage is placed with an unlicensed insurer (40

P.S. § 1006.12). Although not cited in the Order to Show Cause, the Commissioner notes that Respondents' policies and rates have not been approved.

The Department also cites Respondents for violations of the Unfair Insurance Practices Act for misrepresentation (40 P.S. § 1171.5(a)(i)). Considering Respondents have been engaging in insurance activities by misrepresenting they are an ERISA operation, violation of this section is obvious. The Commissioner does not find the other cited section of the Unfair Insurance Practices Act to be applicable to this situation and finds no violations of Section 5(a)(7)(ii) with respect to discriminatory treatment of insureds.

PENALTIES

The continued operation of Respondents' illegal MEWA presents a clear and immediate danger to Pennsylvania employers and employees. Based upon the authority granted under the Unfair Insurance Practices Act, Respondents shall be ordered to cease and desist from soliciting new subscribers and renewing current coverage of subscribers in violation of Section 5(a)(1)(i) of the Unfair Insurance Practices Act.

The failure of Respondents to comply with Pennsylvania's licensing requirements subjects them to a maximum penalty of $10,000 for each offense. The record supports a finding of nine (9) illegal sales for $90,000 civil penalty.

Pursuant to the personal liability imposed by Section 605 of the Insurance Department Act, Respondents shall also make restitution of all premiums, enrollment fees, and administrative fees paid by Pennsylvania subscribers.

ORDER

Based on the pleadings and affidavits submitted by the parties, the Commissioner HEREBY ORDERS THAT:

1. The Insurance Department's Motion for Summary Judgment, as amended, is GRANTED.

2. Respondents are ordered to cease and desist soliciting subscribers in Pennsylvania in violation of the Unfair Insurance Practices Act.

3. Respondents are ordered to cease and desist renewing policies or accepting premium payment in violation of the Unfair Insurance Practices Act.

4. Respondents are jointly and severably liable for a civil penalty of $90,000 representing $10,000 for unlicensed activity involving the solicitation and sale of health and welfare benefits to:

1. Doninic Albanese Electrical and Mechanical
2. Skyview Satellite Service
3. Trattoria Siciliano
4. Yost Family Enterprises
5. Rite-Craft, Inc.
6. Write-Way Distributors, Inc.
7. Pine Grove Ford, Inc.
8. Bucher's Meats
9. Brian L. Reigart, DDS

5. Respondents are individually liable to all subscribers for any and all claims and shall return all premiums and fees collected from Pennsylvania subscribers within thirty (30) days of this Order.

6. Payment of the $90,000 civil penalty shall be remitted within thirty (30) days by certified check to Neva J. Cichy, Docket Clerk, Pennsylvania Insurance Depart-

ment, Administraaive Hearings Office, 1326 Strawberry Square, Harristown State Office Building No. 1, Harrisburg, Pennsylvania, 17120.

7. Within thirty (30) days of the date of this Order, Respondents shall provide a written statement that they have ceased operating in Pennsylvania and that they have complied with the terms of this Order. Such statement shall be directed to Gregory Martino, Director, Bureau of Consumer Services, Pennsylvania Insurance Department, 1321 Strawberry Square, Harristown State Office Building No. 1, Harrisburg, Pennsylvania, 17120.

/s/ Constance B. Foster
CONSTANCE B. FOSTER
Insurance Commissioner

No. 93-684

IN THE SUPREME COURT OF THE
UNITED STATES

OCTOBER TERM 1993

ATLANTIC HEALTHCARE BENEFITS TRUST,
et al.,

Petitioners

v.

CYNTHIA M. MALESKI, et al.,

Respondents

On Petition for Certiorari to
the United States Court of
Appeals for the Third Circuit

RESPONDENT MALESKI'S BRIEF IN OPPOSITION

ERNEST D. PREATE, JR.
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BEST AVAILABLE COPY

QUESTIONS PRESENTED

1. Whether Pennsylvania's insurance licensure laws, as applied to the petitioners, are inconsistent with the relevant provisions of the Employee Retirement Income Security Act of 1974?

2. Whether Pennsylvania's insurance licensure laws, as applied to the petitioners, violate the due process or equal protection clauses?

LIST OF PARTIES

The parties listed in the petition for certiorari are accurate, except that respondent Constance B. Foster, the Insurance Commissioner of Pennsylvania, has been succeeded in that office by Cynthia M. Maleski, who should be substituted for her. See Sup. Ct. R. 35.3.

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STATEMENT OF THE CASE

This case arises out of the respondent Pennsylvania Insurance Commissioner's enforcement action to shut down the petitioners' unlicensed insurance business. Petitioners responded by claiming that the Pennsylvania laws under which the respondent acted are inconsistent with the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 et seq. (ERISA), and are otherwise unconstitutional.

1. United Healthcare Association of America, Inc., one of the petitioners, is a Virginia corporation formed "to enable employers to associate with one another to provide health and welfare benefits to their employees and dependents. " C.A.

App. 120.[1] In March of 1991, the Association established the Atlantic Healthcare Benefits Plan for this purpose. C.A. App. 118, 120. The Plan holds itself out to be a "multiple employer welfare arrangement" or "MEWA" within the meaning of ERISA, C.A. App. 120, see 29 U.S.C. § 1002(40)(a), and it is self-funded, that is, it is not insured. C.A. App. 120. The Association appointed National Insurance Consultants, Inc., another petitioner, as the Plan Administrator to market and administer the Plan on a day-to-day basis, C.A. App. 9, 122; and established the Atlantic Healthcare Benefits Trust--the third petitioner--to hold and invest the Plan's assets. C.A. App. 9, 20.

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[1]The designation "C.A. App." refers to the Appendix filed in this case in the Court of Appeals.

In June of 1991, the Pennsylvania Insurance Department commenced administrative proceedings against the Association and its president, the Plan Administrator and its owner, and the Trust. Pet. App. 23a. The facts of the case were not disputed, Pet. App. 27a, and after briefing from both sides the Insurance Commissioner issued a decision in November of 1991. She found that the petitioners were marketing and selling a health and medical benefits plan which constituted insurance, Pet. App. 34a-35a; that they were neither licensed as insurers themselves nor were they providing coverage through a licensed insurer, Pet. App. 24a, 26a; and in short, that they were engaged in the business of insurance without a license. Pet. App. 36a.

The Commissioner held that the petitioners had violated a number of Pennsylvania laws and rejected petitioners' arguments that ERISA pre-emption relieved them from the need to comply with these statutes. Pet. App. 27a-34a. Nothing that Delaware, Kentucky and Maryland had issued similar orders, the Commissioner ordered the appellants to cease and desist soliciting subscribers, renewing policies or accepting premiums; to return all the premiums they had received; and to pay a civil penalty. Pet. App. 26a-27a, 38a-39a.

2. Petitioners did not appeal this decision through the state court system, but instead brought this action in federal court. They claimed that their activities are exempt from state regulation under the pre-emptive provisions of ERISA and that the respondent's enforcement action

violated unspecified constitutional rights. They sought declaratory and injunctive relief.

The respondent moved to dismiss, and the District Court granted her motion, on the ground petitioners had failed to state a claim on which relief could be granted. Pet. App. 3a-21a.[2]

The District Court assumed for the sake of argument that petitioners' Atlantic Healthcare Benefits Plan was an "employee welfare benefit plan" within the meaning of ERISA, and hence covered by ERISA pre-emption. Pet. App. 9a-19a. She held, however, that the Plan was also a non-insured "multiple employer welfare arrangement" or "MEWA"; that in such

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[2]The District Court also dismissed, on the ground of Eleventh Amendment immunity, petitioners' claims against the Pennsylvania Insurance Department, Pet. App. 6a. Petitioners did not challenge this ruling in the Court of Appeals.

cases, ERISA pre-empts only those state laws which are inconsistent with ERISA; and that the Pennsylvania licensing laws to which petitioners had been subjected were not inconsistent with ERISA. Pet. App. 19a-20a. She likewise rejected the petitioners' constitutional claims. Pet. App. 20a-21a.

3. In the Court of Appeals, the petitioners again argued that Pennsylvania's laws governing the licensure of insurance companies are pre-empted by ERISA; and that, in any case, Pennsylvania's licensing laws are void for vagueness because they do not specifically mention MEWA's by name.[3] Petitioner's arguments were virtual carbon copies of

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[3]Petitioners made a number of other arguments as well, including the argument that ERISA itself is unconstitutional, but as these are not repeated in their petition, there is no need to address them.

the arguments they had made to the Second Circuit in Atlantic Healthcare Benefits Trust v. Googins, 2 F.3d 1 (2d Cir. 1993), petition for cert. filed, No. 93-685 (Nov. 1, 1993); and the Third Circuit decided the case without opinion, via a judgment order that cited the Second Circuit's opinion in Googins and the District Court's opinion in this case. Pet. App. 2a. This petition followed.

REASONS FOR DENYING THE WRIT

I. THIS CASE PRESENTS A STRAIGHTFORWARD ISSUE OF STATUTORY CONSTRUCTION ON WHICH THE COURTS OF APPEALS ARE IN ACCORD WITH EACH OTHER AND WITH THIS COURT.

The primary issue petitioners present is whether ERISA pre-empts state insurance licensure laws, as applied to ERISA welfare benefit plans such as theirs. Pet. 9-10. Petitioners claim that this issue is fraught with "interpretive ambiguities," which have spawned conflicting decisions among the Courts of Appeals, and that the decision in this case conflicts with decisions of this Court as well. Pet 9. The truth, however, is just the opposite: this statutory construction issue is easily resolved by resorting to the plain language of the statute; both Courts of Appeals to have considered this issue have reached the

same result; and that result conflicts with no decision of this Court. We turn first to the statutory language.

1. ERISA's pre-emption provisions are contained in 29 U.S.C. § 1144, reprinted at Pet. 2-3. At its broadest, ERISA pre-emption "was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with [ERISA]." Metropolitan Life Insurance. Co. v. Massachusetts, 471 U.S. 724, 739 (1985).

In 1983, however, Congress amended ERISA to enhance the authority of the States to deal with the growing problem posed by so-called "multi-employer trusts"--commercial enterprises which had sprung up in ERISA's wake and were operating effectively free of either state of federal regulation. Many of these enterprises were under-funded, mismanaged

or outright fraudulent, and left thousands of beneficiaries stranded with unpaid bills. See Sen. Comm. on Governmental Affairs, Interim Report on Combating Fraud and Abuse in Employer Sponsored Health Benefits Plans, S. Rep. No. 102-262, 102nd Cong., 2nd Sess. 3-4 (1992). In response, Congress enacted the Erlenborn-Burton Act, 96 Stat. 2611, to "remove[] any potential obstacle... which could hinder the ability of the States to regulate multiple employer welfare arrangements to assure the financial soundness and timely payment of benefits under such arrangements." 128 Cong. Rec. 30357 (1982)(remarks of Rep. Erlenborn).

The Erlenborn-Burton Act added to ERISA the concept of the "multiple employer welfare arrangement" or "MEWA," defined simply as "any ... arrangement" established to offer benefits to the

employees of two or more employers. 29 U.S.C. § 1002(40)(A).

To enable the States better to protect the beneficiaries of MEWA's, the Act also amended ERISA's pre-emption provisions by adding a new sub-paragraph (6) to Section 1144(b). 29 U.S.C. § 1144 (b)(6). Under sub-paragraph (6), employee welfare benefit plans which are also MEWA's, and which are fully insured, are subject to state insurance laws, to the extent that those laws require the maintenance of minimum reserve and contribution levels. Id., § 1144(b)(6)(A) (i). In the case of employee welfare benefit plans which are MEWA's, and which are not fully insured, "any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title." 29 U.S.C.§ 1144(b)(6)(A)(ii)(emphasis added).

In this case, the District Court assumed that petitioners' Plan qualified as an employe welfare benefits plan, Pet. App. 19a, and the petitioners admit that their Plan is a MEWA and that it is uninsured. Pet. 6. The conclusion is thus inescapable, and petitioners seem to concede, Pet. 5, that they and their Plan are subject to "any law of [Pennsylvania] which regulates insurance" as long as those laws are not actually inconsistent with Title I of ERISA.

2. State insurance licensure laws, as such, are not inconsistent with Title I of ERISA; and there are no conflicts, among the Courts of Appeals or otherwise, on this issue. Only two Courts of Appeals have decided this issue: the Second Circuit in Atlantic Healthcare Benefits Trust v. Googins, 2 F.3d 1, and the Third Circuit in this case, and both reached the

same result. The Department of Labor, charged with enforcing ERISA, likewise agrees. Department of Labor Opinion No. 90-18A [available at 1990 LEXIS ERISA 26].

What petitioners mischaracterize as "conflicts among the states" on this issue, Pet. 9, are not conflicts at all, but simply different regulatory approaches which are the natural result of Congress' decision to authorize state regulation in this area. There is thus no occasion for the Court to review this case to settle any "conflicts" among the lower courts.

Nor does the Court of Appeals' decision conflict, as the petitioners suggest, Pet. 9-10, with FMC Corp. v. Holliday, 498 U.S. 52 (1990). The pre-emption provisions which govern this case apply only to MEWA's, that is, to multiple employer plans. Holliday, in contrast, involved a welfare plan established by a

single employer and was governed by quite different provisions. 498 U.S. at 54, 57-58. In deciding Holliday, the Court naturally had no reason to construe, to consider, or even to mention the MEWA-specific provisions of Section 1144(b)(6), and in fact the Court did not do so. Holliday, far from being controlling here, is thus not even apposite.

3. Finally, petitioners argue that even if state insurance laws are not, in general, inconsistent with Title I of ERISA, Pennsylvania's laws in particular are. Pet. 12. Issues that turn on peculiarities in the laws of individual States, however, are not the sort of issues that justify the exercise of the Court's discretionary jurisdiction, and are better left to the Courts of Appeals.

In any event, the petitioners are wrong that it is a "physical

impossibility," Pet. 14, to comply simultaneously with both ERISA and Pennsylvania's licensing laws.

Petitioners rely mainly on the idea that ERISA--specifically, 29 U.S.C. § 1003(a)--requires that plan assets be held in a trust, and that a trust, as opposed to a corporation, cannot obtain an insurance license in Pennsylvania. Pet. 12. However, as petitioners' Plan was both sponsored and administered by corporations, supra at 1-2, this hardly seems a serious argument. In addition, ERISA provides that plan assets which are held by an insurance company or which consist of insurance polices need not be placed in a trust. 29 U.S.C. § 1003(b)(1), (2). There was thus no structural barrier to petitioners complying with both ERISA and Pennsylvania insurance law.

II. PETITIONERS' CONSTITUTIONAL CLAIMS, WHATEVER THEY ARE, DO NOT WARRANT REVIEW BY THE COURT.

Petitioners' constitutional claims Pet. 15-16, are almost unintelligible, and this alone is sufficient reason to deny their petition. Sup. Ct. R. 14.5. If they are attempting to reprise the void-for-vagueness argument they made in the Court of Appeals--that Pennsylvania's laws are void for vagueness because they do not mention MEWA's by name--then that argument presents no novel or important issues, and was correctly resolved by the Court of Appeals by the routine application of well-established principles. See, e.g., Village of Hoffman Estates v. The Flipside, Hoffman Estates, Inc., 455 U.S. 409, 498-99 (1982). If they are attempting to argue anything else, then they are foreclosed by their failure to argue it below.

CONCLUSION

For these reasons, the respondent asks the Court to deny the writ of certiorari.

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